Patient Referral Form

Mon Health SM Medical Center

Cardiothoracic Surgery
P:304-598-1996
F:304-285-2107

Dermatology
P:304-599-1448
F:304-598-7219

Gastroenterology
P:304-598-2700
F:304-598-2725

Cardiology–Morgantown
P:304-599-8802
F:304-599-5607

Cardiology–Elkins
P:304-636-5006
F:304-636-4898

Cardiology–Fairmont
P:304-363-6210
F:304-363-0952

Medical Oncology
P:304-598-6560
F:304-285-2230

Gynecologic Oncology
P:304-285-3870
F:304-598-6576

Neurology
P:304-594-3258
F:304-594-3498

Obstetrics & Gynecology
P:304-599-6811
F:304-599-7159

Oculofacial Surgery
P:304-598-2200 ext 115
F:304-413-2222

Pulmonology
P:304-598-2801
F:304-599-6463

Radiation Oncology
P:304-285-2220
F:304-285-2222

Rheumatology
P:304-598-7296
F:304-598-7297

Sleep Center
P:304-599-7934
F:304-599-7936

General Surgery–MHMP
P:304-599-1448
F:304-599-5335

General Surgery–Suncrest
P:304-598-2200 ext 115
F:304-599-2674

Urology
P:304-599-3074
F:304-599-1802

Vein Care
P:304-598-3449
F:304-285-2739

Wound Care
P:304-285-1460
F:304-285-2739

If available, please fax the following records with this form to obtain an appointment:

[ ] Pathology Reports
[ ] Imaging (US, MRI, CT, PET, Echocardiogram, Cardiac Stress Test)
[ ] Lab Results
[ ] List of Current Medications
[ ] Last Office Note
[ ] Copy of Current Insurance Card

[ ] Routine [ ] Medically Urgent [ ] Pre-Op Evaluation

PATIENT INFORMATION:

First_____ MI_____ Last Name_____

DOB:_____/_____/_____ SS# _____-_____-_____

Home Phone: (_____)-_____-_____ Cellphone: (_____)-_____-_____

Address:_____

City_____State_____Zip_____

REFERRING PHYSICIAN INFORMATION:

Physician Name:_____

Name of person faxing information:_____

Office Fax:_____Office Phone:_____

Reason for Visit/Symptoms:_____

_____

Requested Physician _____First Available _____

OFFICE USE ONLY

Patient has Appointment with:

Dr.:_____on_____at_____